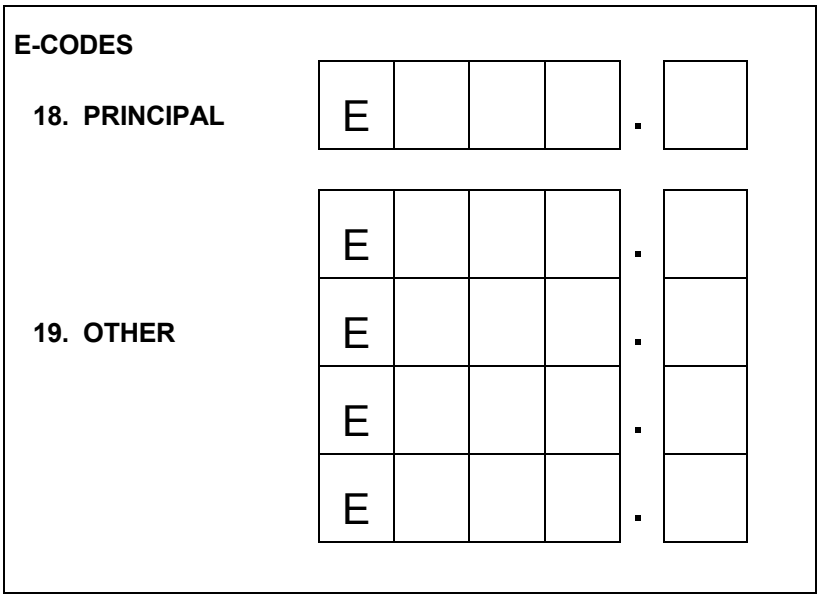
EXTERNAL CAUSE OF INJURY — Section 97227

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported on the record for the discharge during which the injury, poisoning, and/or adverse effect was first diagnosed and/or treated. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect.

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for discharges occurring on or after January 1, 2005:



Reporting Requirements:

- The external cause of injury, poisoning, or adverse effect shall be coded to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), using the E-codes.
- Reporting medical/surgical misadventure and abnormal reaction codes (categories E870-E879) is optional.
- Duplicate E-codes will not be accepted on the same data record. This is consistent with the guidelines for E-codes in Coding Clinic for ICD-9-CM.
- If more than one drug or substance caused a poisoning or adverse effect, report all E-codes necessary to describe all substances.
- Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) must never be reported in the Other Diagnoses code fields. Such codes must only be reported in the External Cause of Injury code fields.

Principal E-code:

- Defined as the external cause of injury or poisoning or adverse effects which describes the mechanism that resulted in the most severe injury, poisoning, or adverse effect.
- If sequencing the external cause of the most severe injury as the principal E-code is contradictory to the guidelines given in ICD-9-CM, OSHPD reporting requirements take precedence.

Other E-codes:

- Defined as additional ICD-9-CM codes from the range E800-E999 necessary to completely describe the mechanisms that contributed to or the casual events surrounding the injuries, poisonings, or adverse effects.
- Include category E849 (place of occurrence) if documented in the medical record.

Place of occurrence codes (category E849) are:

- Invalid as the principal E-code.
- Reported to OSHPD if the principal E-code does not specify the place of occurrence.

- Reported to OSHPD as unspecified (E849.9) when the place of occurrence is not specified in the medical record.

- If none of the reported E-codes describe the place of occurrence, then include a place of occurrence E-code as one of the four Other E-codes.

Number of Other E-codes: Four other E-codes in addition to the principal E-code may be reported to OSHPD.

- When multiple E-codes are required to completely classify the cause(s), the principal E-code and up to three additional E-codes need to describe **how** it happened. If the principal E-code does not include a description of **where** it happened, report the E-code for the place of occurrence (E849.x) in the remaining field.

- If your reporting format limits the number of E-codes that can be used in reporting to OSHPD, refer to the Coding Clinic for ICD-9-CM for coding multiple E-codes in the same three-digit categories or different three-digit categories. In either case, include the E-code for the place of occurrence (E849.x).

Which record reports the E-code – Inpatient? ED? AS?

If the injury or poisoning or adverse effect was first diagnosed and/or treated during the ED or AS encounter, then report the E-Code on the ED or AS encounter record.

However, if the ED or AS encounter resulted in a same-hospital admission and your hospital combines the ED or AS record with the inpatient record, then the E-code would be reported on the inpatient record.

Examples

<u>Injury During the Stay:</u>

1) Fall from bed:
If the patient fell from a bed and an injury (e.g. bruise) occurred, the injury would be coded as an Other Diagnosis, and an E-code for the fall from the bed would be reported. Another E-code would be reported for the place of occurrence.

2) Suicide Attempt
If the patient attempts suicide with a drug overdose during the stay at Hospital A, the E-code(s) needs to be reported by Hospital A.

Drug Reaction During the Stay:
Occasionally a patient may experience a reaction to a drug given at your facility. The reaction (hives, arrhythmia, lethargy, etc.) would be coded as a diagnosis, an E-code for the name of the therapeutic drug would be reported, and another E-code would be reported for the place of occurrence.

Treated in ED at Same Facility:
If the patient was first treated in the ED of Hospital A and is then admitted as an inpatient to Hospital A, the E code(s) needs to be reported on the inpatient record.

Treated in ED and Transferred:
If the patient was first diagnosed and treated in the ED of Hospital A and then transferred to the Hospital B, the E code(s) needs to be reported only on the ED record of Hospital A. Hospital B does not report the E-code.

Treated at Freestanding ASC and Transferred to Hospital:
If the patient was first treated in a freestanding ASC and then transferred to Hospital A, the E code(s) needs to be reported on the AS record by the freestanding ASC. Hospital A does not report the E-code.

DISCUSSION:

Domestic Violence, Abuse, and Neglect using Diagnosis and E-codes

Domestic violence, abuse, and neglect are considered to be under-reported and under-diagnosed. Community awareness of these circumstances is growing and there is a need for data collection on its incidence. Using this data, the healthcare communities can then develop solutions in helping both the victims and the perpetrators.

If the incident of domestic violence, abuse, or neglect is documented in the patient record, the ICD-9-CM classification system provides codes for:

- diagnosis of physical abuse, mental abuse, sexual abuse, and neglects (physical, emotional, educational, medical, or social) using the 995.5 and 995.8 series,
- specific associated injuries using 001-999 series,
- external causes for the nature of these incidents and the perpetrator using the assault E-codes and the E967 series,

- past history of physical or emotional abuse using the V15.4 series, and

- counseling for victims and/or perpetrators using the V61.1-V61.2 series, and/or V62.83 code.

The codes for these incidences are assigned only when the physician documents the abuse, neglect, or domestic violence. The narrative descriptions should not be interpreted as abuse without the physician's confirmation. In accordance with the Penal Code and AMA reporting policy, physicians who suspect abuse should report it to the appropriate authorities.

Coding Clinic for ICD-9-CM published the Official Guidelines for Coding and Reporting in the 2nd Quarter 2002, pages 21-71 and 4th Quarter 2002, pages 115-182, in addition to the following:

Abuse/Neglect for Diagnosis and/or E Codes:
Refer to Coding Clinic for ICD-9-CM: 4th Quarter 1996, pages 38-45 and 77-78; 1st Quarter 1998, page 11; 4th Quarter 1995, pages 39-40; 4th Quarter 1996, pages 77-78; 3rd Quarter 1999, pages 14-16; and 4th Quarter 2000, page 62.

Questionable or Suspected or Rule Out or Uncertain Diagnosis:
Refer to Coding Clinic for ICD-9-CM: May-June 1984, page 4; March-April 1985, page 3; March-April 1986, page 8; 1st Quarter 1990, page 4 and 14; 1st Quarter 1991, pages 12-13; 4th Quarter 1995, pages 40 and 45-46; 4th Quarter 1996, pages 77-78; and 3rd Quarter 2001, page 17.

Unknown or Undetermined Cause:
Refer to Coding Clinic for ICD-9-CM: 4th Quarter 1995, pages 33-41; and 4th Quarter 1996, pages 77-78.

Penal Codes:
Refer to California Penal Code sections 11160-11163 for reporting injuries and sections 11164-11174 for reporting child abuse and neglect.

American Medical Association:
Refer to “Diagnostic and Treatment Guidelines on Elder Abuse and Neglect”, issued in 1993 or any of AMA updated policies for reporting child or elder injuries to authorities at http://www.ama-assn.org/ama/pub/article/2036-5298.html.

Consent Manual by California Healthcare Association:
Refer to release of information without patient authorization when there is suspected child abuse and neglect [42 C.F.R. section 2.12(c)(6)]. Refer to statutory reporting requirements for abuse of elders or dependent adults [California Penal Code sections 288 and 368; Welfare and Institutions Code sections 15610 and 15630-15634}.